

County of Los Angeles – Department of Mental Health
Countywide Housing, Employment & Education Resource Development (CHEERD)
Request for CHEERD Housing Resource for Families

Family = household with a minor

To be considered for a CHEERD Housing Resource for Families, please complete and fax this form to **Yvette Fierro** at **213-637-2336**. CHEERD will triage the referrals and determine the housing program your client will be assigned to: Shelter Plus Care, Homeless Section 8, MHSA Housing Program (project-based) or Tenant Based Supportive Housing Program.

Please DO NOT begin completing any application packet until you receive approval from CHEERD.

Client Information (please print)

| | | | | | | | | | | | |
|--|--|-------|---------------------|----------------|--|---|--------------------|--|--|--|--|
| IS/IBHIS Number: | | Date: | | Date of Birth: | | Social Security Number: | | Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female | | | |
| Client Last Name: | | | Client First Name: | | | Head of Household: <input type="checkbox"/> No <input type="checkbox"/> Yes | | Veteran: <input type="checkbox"/> No <input type="checkbox"/> Yes | | Housing Preference: <input type="checkbox"/> Project-Based <input type="checkbox"/> Tenant-Based | |
| If Client is a Minor, Adult's Last Name: | | | Adult's First Name: | | | Head of Household: <input type="checkbox"/> No <input type="checkbox"/> Yes | | Relationship to Minor: | | Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female | |
| Receiving services from: <input type="checkbox"/> FSP <input type="checkbox"/> FCCS <input type="checkbox"/> CalWORKs <input type="checkbox"/> Wellness <input type="checkbox"/> Project 50 Replications <input type="checkbox"/> Other MH Program (explain): _____ | | | | | | Priority Score (1-3) | SPDAT Score (0-17) | Family Size: # of Adults # of Minors | | Total Monthly Household Income \$ | |
| Does the head of household have legal custody of the minor(s)? <input type="checkbox"/> No <input type="checkbox"/> Yes | | | | | | | | | | | |
| Income Source (check all that apply): <input type="checkbox"/> Earned Income <input type="checkbox"/> Veteran's Disability <input type="checkbox"/> Worker's Compensation <input type="checkbox"/> CalWORKs or TANF <input type="checkbox"/> Unemployment Insurance <input type="checkbox"/> Veteran's Pension <input type="checkbox"/> General Assistance/ GR <input type="checkbox"/> Pension from another job <input type="checkbox"/> SSI <input type="checkbox"/> Child Support <input type="checkbox"/> Supplemental Nutrition Assistance <input type="checkbox"/> Alimony (spousal support) <input type="checkbox"/> SSDI <input type="checkbox"/> Private Disability Insurance <input type="checkbox"/> Other (explain): _____ | | | | | | | | | | | |

Agency/Clinic Information (please print)

| | | | | | |
|----------------|--|-------------------------------|--|---------------|--|
| Agency/Clinic: | | Housing Liaison/Case Manager: | | Service Area: | |
| Email Address: | | Phone Number: | | Fax Number: | |

History of Homelessness

Provide a **3-year timeline** of client's housing / homelessness history. Attach a separate sheet if necessary.

For CHEERD staff use only. Please DO NOT complete below.

| | | | |
|---|--|----------------------------------|--|
| Date Entered into CHEERD Database: _____ | | Entered into Database by: _____ | |
| Date Referral Forwarded to HP&D: _____ | | Processed by (HP&D staff): _____ | |
| Approved: <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, what resource was client assigned to: _____ | | | |
| Date Referral Forwarded to FHSU: _____ | | Processed by (FHSU staff): _____ | |
| Approved: <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, what resource was client assigned to: _____ | | | |